Figure SC810.F11. Form CA-2a, "Federal Employee's Notice of Recurrence of Disability and Claim for Continuation of Pay/Compensation" with Instructions

Notice of Recurrence

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Complete Part A below.
Employing Agency (Supervisor or Compensation Specialist): Complete Part B.
Note: Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0167
Expires: 08-31-99

Part A - Employee

1. Name of employee (Last, First, Middle)	2. Social Security Number	3. OWCP file number for original injury
JONES, John E.	111-22-3344	A00-123456

4. Date of birth (Mo. Day Yr.)	5. Sex	6. Home telephone
06 02 57	[X] Male [ ] Female	(111) 234-5678

7. Home mailing address (include city, state, and ZIP code)
318 Pine Street
Richmond, VA 23297

8. Dependents
[ ] Wife, Husband
[ ] Children under 18 years
[ ] Other

9. Name and Address of Employing Agency at time of original injury (number, street, city, state, ZIP code)	10. Name and Address of Employing Agency at time of recurrence, if other than shown in 9. If you are no longer employed with the Federal Government, complete Part C also.
Naval Weapons Station Code 0641 Yorktown, VA 23297	Same as item 9

11. Date and Hour of original injury (mo., day, year)	12. Date and Hour of recurrence (mo., day, year)	13. Date and Hour stopped work after recurrence (mo., day, year)	14. Date and Hour pay stopped after recurrence (mo., day, year)	15. Date and Hour returned to work (mo., day, year)
11/5/94 1:30 PM	2/3/95 10:15 AM	2/3/95 10:15 AM	Hasnt stopped	N/A

16. This Claim is for:	17. Date of first medical treatment following recurrence (mo., day, year)	18. Name and address of treating physician
[ ] Medical Treatment Only [X] Time Loss From Work	2/3/95	A.C. Jones, MD 1098 Smith Rd. Richmond, VA 23297

19. After returning to work following the original injury, were you in any way limited in performing your usual duties? [X] Yes [ ] No
(If so, explain. Also state how long these limitations continued.)
limited to lifting no more than 20 pounds. usual duties require 40 pound lifting

20. Describe your condition since you returned to work, including the nature and frequency of all medical treatment received.
continued to have moderate back pain--participated in therapy program and did back strengthening exercises at home.

21. Describe how and when the recurrence happened. Explain why you believe your current condition is related to the original injury.
doing paperwork at desk when back pain became severe,I was doing nothing different from day to day duties.

22. Describe all injuries and illnesses which you suffered between the date you returned to work after the original injury, and the date of recurrence Arrange for the submission of all relevant medical records.
I have had no injuries or illnesses since the original injury.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain compensation as provided by the Federal Employees' Compensation Act (FECA), or who knowingly accepts compensation to which that person is not entitled, is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

I hereby claim medical treatment if needed, and up to 45 days Continuation of Pay if disabled for work.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

I certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge.

23. Signature of employee	24. Date (mo., day, year)
John E. Jones	2/7/95

Form CA-2a

Part B – Federal Employing Agency

25. Name and address of reporting office (include city, state, and ZIP Code)
Human Resources Office-Code 0641

Naval Weapons Station
Yorktown, VA 23691-5000
ZIP Code

OWCP Agency Code

OSHA Site Code

26. Employee's duty station (street address and ZIP Code)
Same as item 25
ZIP Code

27. Date of first return to FULL-TIME REGULAR duty following original injury
Mo. Day Yr.
12 13 94

28. Regular work hours From: 0730 [X] a.m. [ ] p.m. To: 0400 [ ] a.m. [X] p.m.

29. Regular work days [ ] Sun. [X] Mon. [X] Tues. [X] Wed. [X] Thurs. [X] Fri. [ ] Sat.

30. Date of injury Mo. Day Yr. 11 05 94

31. Date of recurrence Mo. Day Yr. 02 03 95

32. Date stopped work after recurrence Mo. Day Yr. 02 03 95 Time 10:15 [X] a.m. [ ] p.m.

33. Date pay stopped after recurrence Mo. Day Yr.
Has not stopped

34. Dates COP paid for recurrence From Mo. Day Yr.
To
None

35. Date returned to work after recurrence Mo. Day Yr. Time : [ ] a.m. [ ] p.m.
Has not returned

36. Did the employee receive medical care at an agency facility due to the recurrence? If so, please attach all relevant medical records. [ ] Yes [X] No

37. At the time of the recurrence did your agency authorize medical treatment on Form CA-16? [ ] Yes [X] No

38. After the original injury, did you make any accommodations or adjustments in the employee's regular duties due to injury-related limitation? [X] Yes [ ] No If so, provide full details.

Employee was restricted to lifting no more than 20 lbs. He was assigned to input inventory data and answering the telephone for two months.

39. After return to work, did the employee sustain any other injury or illness which affected performance of his or her duties? If so, provide full details.

N/A

40. Please review the statements made by the employee in Part A of this form and provide any relevant comments and additional information.

I have reviewed the comments. I was aware that John continued to have back pain and used aspirin to relieve the pain.

A supervisor or compensation specialist who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

41. Signature of Supervisor or Compensation Specialist (at time of recurrence)	42. Title	43. Work phone	44. Date (mo., day, year)
James Sherwood	Chief, B&B Section	(111)234-5678 ( )	2/12/95